Revisions to Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Rules

Overview

A Notice of Proposed Rulemaking (NPRM) containing revisions to the Medicaid and CHIP managed care rules issued in 2016 by the Center for Medicare and Medicaid Services (CMS) was published in the *Federal Register* on November 14. The comment period on the NPRM closes January 14. The proposed rule changes "are intended to ensure that the regulatory framework is efficient and feasible for states to implement in a cost-effective manner and ensure that states can implement and operate Medicaid and CHIP managed care programs without undue administrative burden."

In a letter to Governors issued in March of 2017, the Department of Health and Human Services (HHS) had earlier indicated it would fully review the original regulation issued by the Obama administration in response to concerns raised by states. The proposed rule includes a number of substantive changes that provide states more flexibility around network adequacy and rate setting, while retaining existing protections for actuarial soundness. The proposal, however, makes only minor technical changes to medical loss ratio (MLR) calculations and offers no additional flexibility to the 15-day limit on inpatient stays at Institutions for Mental Diseases (IMDs), an issue that has been separately addressed in legislation recently passed by Congress and waivers authorized by HHS/CMS.

A listing of the major provisions included in the proposed rule as well as commentary follows below.

Coordination of Benefits Agreements (COBA)

Removes a requirement that Medicaid managed care organizations (MCOs) and other managed care entities have COBAs with Medicare and allows states to specify in MCO contracts a methodology for ensuring that managed care plans receive the proper crossover claims. This will help avoid confusion where not all Medicaid services are provided by the same managed care entity or when enrollees move between plans.

This change should reduce administrative burdens for MCOs and confusion for enrollees.

Capitation Rates

1) Provides an option for states to certify rate ranges for rate cells with a variation of up to five percent. States using this rate range option would not be able to use existing flexibility to modify capitation rates plus or minus 1.5 percent during the contract year. States would need to document the capitation rates prior to the start of the rating period for each applicable managed care entity. Under this option, states certifying a rate range would need to ensure that the rate certification identifies and justifies the assumptions, data, and methodologies specific to both the upper and lower bounds of the rate and that these bounds are actuarially sound. Any changes in rates would require states to submit a revised certification that justifies any modifications.

While providing more flexibility to states, this change creates more uncertainty about rates for Medicaid MCOs.

2) Clarifies that states can adjust rates up or down during a contract year by up to 1.5 percent without submitting a new rate certification or justification to CMS, but only if they do not utilize the new rate range option described

above. Such adjustments cannot be used to shift costs to populations with higher FFP and must meet all other criteria for setting rates, including actuarial soundness.

Allowing mid-year rate adjustments in conjunction with the new rate range option for states would create even more uncertainty for MCOs.

3) Codifies requirements for CMS to issue annual capitation review guidance that allows for accelerated review.

This ensures more transparency for the rate review process, although it does not give MCOs more insight into CMS's review of rate certifications.

4) Adds new requirements to prohibit the use of varied assumptions, methodologies, or factors used to develop rates based on the federal financial participation (FFP) associated with different populations and requires comparison of rates between all managed care contracts. The proposed rule includes a non-exhaustive list of rate development practices (e.g., the use of a higher profit margin, operating margin, or risk margin for a covered population that exceeds the margins used for a covered population or contract with the lowest FFP).

This will make it more difficult for states to shift costs between populations based on FFP and should lead to more consistent application of rating factors.

5) Prohibits states from retrospectively adding or modifying risk-sharing arrangements such as reinsurance, risk corridors, and stop-loss limits and requires such mechanisms to be documented in a state's contract and rate submissions.

This could limit the ability of states to correct mistakes in actuarial assumptions, making it even more important that state rate certifications are adequately justified.

<u>Directed Payments</u>

Provides two new options for directed payments. The first allows a state to direct managed care entities to pay the State Plan fee-for-service (FFS) rates, exclusive of supplemental payments, without further approval from CMS. The second option allows plans to adopt a cost-based rate, Medicare equivalent rate, or commercial payer rate. Also allows for multi-year directed payments as part of value-based purchasing, as well as global or bundled payments.

These flexibilities need to be fully accounted for in determining whether MCO capitation rates are actuarially sound.

<u>Pass-Through Payments</u>

Allows for up to a three-year transition period for continuing pass-through payments to hospitals, nursing facilities, and physicians for services covered for the first time under managed care so long as the aggregate amount of such payments does not exceed the total amount paid in the 12-month period immediately two years prior to the rating period of the pass-through payment transition period. This transition period would be available under both new Medicaid managed care programs and expansions of Medicaid managed care to new populations. The proposed rule includes a formula for ensuring that payments to individual provider types covered under this

provision would be no more than their proportion of the total paid in the 12-month reference timeframe. CMS is seeking comment on whether a 3-year transition period is appropriate.

These payments, which CMS notes are disconnected from the amount, quality, or outcomes of services, make it more difficult to achieve actuarially sound capitation rates for the duration of the transition period.

Beneficiary Information Requirements

Aligns requirements for the use of large-print taglines with those for translation of documents into prevalent non-English language by only requiring states to require such taglines in materials that "are critical to obtaining services." States are still able to require taglines for additional materials. The proposed rule also would allow paper provider directories to be updated quarterly rather than every 30 days if an MCO has a mobile-enabled electronic directory.

These changes should prove helpful to both states and plans in terms of reducing administrative burdens while retaining essential consumer protections.

Network Adequacy Standards

Changes requirement for states to use time and distance network adequacy standards and allows them to utilize other quantitative standards such as provider-to-enrollee ratios, hours of operation, and maximum wait times for appointments. Also clarifies that states should define term "specialist" for purpose of developing network adequacy standards for the provider category.

These changes will prove helpful to both states and MCOs by allowing standards that take into account specific factors applicable to individual states, such as the supply of providers and geography.

Enrollee Encounter Data

Affirms a provision of the original final rule requiring that reported data include both the allowed amount and paid amount for claims while committing CMS to treating this data as trade secret when requirements for such classification are met.

Managed care plans consider this information to be proprietary and have been concerned about its disclosure.

Medicaid Quality Rating System (QRS)

Modifies the Medicaid managed care QRS framework to give states the ability to utilize an alternative state QRS without CMS approval so long as they still incorporate federally mandate performance measures. While a state QRS would still need to be comparable to the CMS developed QRS, states would be able to take into account differences in covered populations, benefits and the status of delivery system reform in showing substantial comparability.

This will allow individual states to tailor their QRS frameworks to better fit their programs, but makes comparison between states more challenging. Multistate MCOs may also find it more difficult to conduct QI initiatives across a range of QRS frameworks.

Managed Care Quality Strategy

Clarifies that managed care state quality strategies should generally include risk-bearing primary care case management (PCCM) organizations and that in developing quality strategies, states should share additional sources of information pertaining to the disability status of enrollees beyond the definition of disability used for Medicaid eligibility.

These changes address confusion created by definitions included in the original Medicaid managed care final rule. All risk-bearing managed care entities should be subject to state quality strategies. The broadened definition of disability is consistent with parameters include in newly approved community engagement (CE)/work requirement waivers.

Grievances and Appeals

1) Removes denials of claims based on administrative issues from the definition of "adverse benefit determinations" that require notification to enrollees.

Reduces administrative burden for MCOs and also reduces anxiety of beneficiaries who are not exposed to any financial liability resulting from an "unclean" claim.

2) Eliminates the requirement of an oral appeal of an adverse benefit determination to be follow by a written appeal.

This should speed up resolution of appeals and reduce the administrative burden of MCOs in seeking submission of written appeals.

3) Aligns timeframes for enrollees to request state fair hearing appeals between Medicaid FFS and managed care by allow no less than 90 calendar days and no greater than 120 days.

Aligning requirements for Medicaid FFS and managed care generally makes sense and creates a more level playing field. However, some MCOs may consider 120 days to be an excessive timeframe.

CHIP Managed Care

Clarifies, that unless noted otherwise, compliance with revisions to CHIP regulations included in the final 2016 rule are effective the first day of the state fiscal year beginning on or after July, 2018 whether or not a multi-year contract is in place at that time or a new contract begins on or after that date.

This clears up confusion about the effective date of 2016 CHIP rule changes.